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# THE OREGON MEDICAID PROGRAM: IS IT JUST?

*Maxwell J. Mehlman, J.D. †*

## I. THE OREGON PLAN

IN 1989, THE OREGON legislature enacted Senate Bill 27,<sup>1</sup> which changed the state's Medicaid program by expanding the group of persons eligible to receive benefits under the program.<sup>2</sup> At the time the measure was passed, only approximately 160,000 of the 300,000 Oregonians living below the Federal Poverty Level (FPL) — that is, earning less than \$9,890 per year for a family of three<sup>3</sup> — were eligible to receive care under the state's Medicaid program.<sup>4</sup> The intent of the legislature was to expand the program to provide health care at least to all Oregonians whose incomes were below the FPL.<sup>5</sup>

How is the expansion of the program to be financed? There are a limited number of alternatives. One is to increase program funding, presumably by increasing state taxes.<sup>6</sup> However, Oregon has

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1. Codified within OR. REV. STAT. §§ 414.025 - 414.750 (1989).

2. The legislature also enacted two related pieces of legislation, Senate Bill 935 (codified within OR. REV. STAT. §§ 316.096, 317.113, 353.725, 353.765, 353.775 (1989), which, beginning in 1994, requires employers to make contributions to a state insurance pool to fund basic health care for employees, and Senate Bill 534 (codified within OR. REV. STAT. §§ 735.605 - 735.650 (1989), which establishes an insurance pool, to be funded by insurance companies, to help cover the costs of care for the uninsured. The provisions of Senate Bill 27 are more controversial and will be the focus of this paper.

3. Personal communication from Center on Budget and Policy Priorities, Washington, D.C. (April 16, 1990).

4. HUMAN RESOURCES COMMITTEE OREGON HOUSE OF REPRESENTATIVES, 1989 SESSION, STAFF MEASURE SUMMARY at 1 (June 16, 1989).

5. *Id.*

6. Additional funds might be sought from the federal government, but since the federal government only funds a portion of the costs of the program, the state would have to come up with additional funds of its own.

been hit with a taxpayer revolt,<sup>7</sup> so this alternative is not politically attractive. A second alternative is to reduce payments to providers of care to Medicaid patients. But providers in Oregon already were complaining that their levels of reimbursement were too low, and Medicaid recipients would be unable to obtain access to care if providers were driven away by inadequate compensation.<sup>8</sup> This seems to leave only one alternative: lowering Medicaid expenditures by limiting the medical services that Medicaid would pay for.<sup>9</sup>

Senate Bill 27 adopts this rationing approach. The bill requires the state to contract with prepaid, managed care organizations — i.e. health maintenance organizations — to deliver care to Medicaid recipients.<sup>10</sup> To determine how much these organizations would receive for each Medicaid eligible they enroll, the legislature identifies the services they must provide, and estimates how much these services should cost per enrollee. This enables the legislature to vary the total cost of the state's Medicaid program by expanding or contracting the services that are covered. Senate Bill 27 authorizes a Health Services Commission<sup>11</sup> to determine which services to cover by ranking health services in order of priority "from the most important to the least important."<sup>12</sup> In addition, an independent actuary determines how much the state must pay to cover the providers' costs, and estimates the number of persons who will be enrolled in

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7. See Welch and Larson, *Sounding Board: Dealing with Limited Resources; The Oregon Decision to Curtail Funding for Organ Transplantation*, 319 NEW ENG. J. MED. 171 (1988).

8. The President of the Oregon State Senate, John Kitzhaber, stated, for example: Money can also be saved for the state by cutting provider reimbursement rates. In Oregon, the average provider reimbursement reflects a 55% discount. And while this may help balance the budget in the short run, there are two other consequences. First, a growing number of providers are refusing to see Medicaid recipients, further aggravating the problems of access. Second, those who *do* continue to treat the poor, often shift the uncompensated cost to employers, driving up their premiums. See Kitzhaber, *The Oregon Basic Health Services Act 5* (1989) (unpublished report).

9. Another approach would be to reduce the demand for Medicaid services by improving the health status of Medicaid recipients, such as by providing more preventive care. Since the benefit of preventive care is not immediately realized, however, this would not solve the budget problem in the short run.

10. See Senate Bill 27, sec. 6 (enacted as OR. REV. STAT. § 414.725). The state is authorized to pay providers on a fee-for-service basis in those areas in which prepaid, managed care is not available. See Sec. 6(1) (enacted as OR. REV. STAT. § 414.725(1)).

11. The Health Services Commission consists of 11 members appointed by the governor and confirmed by the state senate, comprising 5 physicians, 4 consumers, a public health nurse and a social services worker. Senate Bill 27, sec. 4(1) (enacted as OR. REV. STAT. 414.715(1)).

12. Senate Bill 27, sec. 4a(3) (enacted as OR. REV. STAT. § 414.720(3)). The statute also states that the ranking should represent "the comparative benefits of each service to the entire population to be served." *Id.*

the program.<sup>13</sup> The legislature then decides which services the program will cover during the next budget cycle<sup>14</sup> by comparing the commission's priority ranking with how much the legislature wishes to spend.<sup>15</sup> The law also stipulates that, if funding for the Medicaid program is insufficient during the budget period — either because the legislature underestimates the number of eligibles who are enrolled in the program or because revenues needed to fund the program are lower than expected — the legislature may not decrease the amounts it contracted to pay providers, and may not decrease the size of the eligible population; instead, it must further reduce the services covered by Medicaid, in the order that they are ranked.<sup>16</sup>

The effect of these provisions is to reduce services to the current Medicaid recipients in order to expand the Medicaid population. Since Oregon anticipates that the actual increase in Medicaid enrollees will occur in increments,<sup>17</sup> this will create a succession of contractions of services over time. Each expanded group of eligibles will be entitled to fewer services than the previous group. The sooner a person enrolls, and the sooner the person is sick, the greater the number of services they can receive.

While the objective of expanding the Oregon Medicaid program is commendable, the means adopted by the Oregon legislature to control the costs of the expansion are problematic. This paper examines the legislature's approach from a legal perspective. The first part of the paper determines whether it is consistent with federal and state law governing the Medicaid program. Oregon is seeking waivers from any conflicting federal requirements,<sup>18</sup> and since there

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13. *Id.*

14. Oregon is on a two-year budget cycle. See Welch and Larson, *supra* note 7, at 171.

15. See Senate Bill 27, sec. 4a(5) (enacted as OR. REV. STAT. § 414.720(5)) ("After considering the recommendations of the Joint Legislative Committee on Health Care [which consults with the Health Services Commission on the commission's findings], the Legislative Assembly shall fund the report to the extent the funds are available to do so.").

16. Senate Bill 27, sec. 8 (enacted as OR. REV. STAT. § 414.735).

17. See, e.g., Shostak, Briefing: The Oregon Response to the Medically Uninsured 3 (July 1989) (unpublished manuscript, Bioethics Consultations Group, Inc.) ("Not all [newly eligible Oregonians] will find their way into the program during the current two year budget cycle. The state believes that by the end of the two year fiscal cycle (June 1991) only 10,000 of these poor but not currently Medicaid eligible persons will be enrolled.").

18. See Lund, *Oregon Plan to Rank Services Rapped as Cutting Benefits*, Am. Med. News, Feb. 16, 1990, at 3, col. 1. The state is seeking a waiver from Congress as well as from the Department of Health and Human Services. *Id.* An important reason for obtaining the waivers is so that the federal government will pay a proportion of the costs of providing medical care to Oregonians who would not normally be eligible for federal cost sharing — basically those who do not qualify for Aid to Families with Dependent Children (AFDC) or

do not appear to be any constitutional impediments, the key question is whether the waivers should be granted as a matter of sound public policy. The second and third parts of the paper explore this question in terms of the two main features of the Oregon plan: priority ranking of medical services, and redistributing Medicaid resources from current to future eligibles. The final portion of the paper considers whether alternative methods of expanding Medicaid eligibility would be preferable.

## II. LEGAL ANALYSIS OF THE OREGON PLAN

The Oregon Medicaid program is governed both by federal and state law. At the federal level, the program is subject to the requirements of the U.S. Constitution, and to the provisions in the federal statutes and regulations concerning Medicaid. At the state level, the program is governed by the Oregon state constitution and by state laws and regulations.

Assuming that the plan is adopted and administered using the correct procedures, it is unlikely to run afoul of the federal or state constitutions. The Supreme Court has made it clear that the Constitution does not require the government to provide health care to its citizens if they are unable to pay for it themselves. In *Maher v. Roe*, for example, the Court stated that "[t]he Constitution imposes no obligation on the States to pay . . . any of the medical expenses of indigents."<sup>19</sup> In other words, there is no constitutional "right" to health care that would prevent the Oregon or federal governments from refusing to pay for certain services for the poor, or from refusing to pay for any services whatsoever.<sup>20</sup> Furthermore, the Supreme Court has held that the government may deny benefits to those too poor to pay for them without denying equal protection of the law.<sup>21</sup>

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for Supplemental Security Income — and whose care would otherwise be paid for entirely with state funds. See HEALTH CARE ACCESS, THE OREGON HEALTH STANDARD, at 9 (1990) (prepared at the direction of The Oregon State Legislature's Joint Legislative Committee on Healthcare) ("Federal Medicaid requirements may stand in the way of the Oregon plan. Congress needs to waive eligibility barriers for single adults and childless couples living in poverty.").

19. 432 U.S. 464, 469 (1977).

20. The Oregon constitution does not contain any provisions that warrant a different conclusion.

Ironically, the only exception to the notion that there is no right to health care is in the case of prisoners; the Supreme Court has held that denying medical care to prisoners is cruel and unusual punishment that violates the fifth amendment. See *Youngberg v. Romeo*, 457 U.S. 307 (1982); *Estelle v. Gamble*, 429 U.S. 97 (1976).

21. The Supreme Court has held that wealth is not a "suspect classification" and there-

In the absence of constitutional obstacles, the legality of the Oregon plan will depend on whether it is consistent with the statutory provisions governing the Medicaid program, and if not, on whether Congress or the Department of Health and Human Services exempts the plan from the statutory requirements by granting waivers. Waivers clearly will be needed to permit the state to expand Medicaid benefits funded in part by the federal government to persons who do not meet the eligibility requirements of federal law.<sup>22</sup> A more controversial issue is raised by the need for waivers for that aspect of the plan that denies medically necessary care to those persons who *must* be covered under Medicaid — the so-called “categorically needy” — so that more people can be eligible.

A number of cases have challenged the refusal of a state Medicaid plan to cover services that were arguably medically necessary for Medicaid recipients.<sup>23</sup> These cases take as their starting point

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fore differential treatment based on wealth does not trigger “strict scrutiny” by the courts. See *San Antonio Indep. School Dist. v. Rodriguez*, 411 U.S. 1 (1973); *James v. Valtierra*, 402 U.S. 137 (1971); *Dandridge v. Williams*, 397 U.S. 471 (1970). The only exception would be if the government denied someone a “fundamental right,” a status that the Court has refused to extend to health care. See *supra* discussion in text accompanying notes 18-19. For example, the Supreme Court has held that a state can provide lower benefits to ADFC recipients than the elderly, blind or permanently disabled without violating equal protection. *Jefferson v. Hackney*, 406 U.S. 535 (1972). The Court, applying limited or “rational basis” scrutiny, stated that, “since budgetary constraints do not allow the payment of the full standard of need for all welfare recipients, the State may have concluded that the aged and infirm are the least able . . . to bear the hardships of an inadequate standard of living.” *Id.* at 549. Following this precedent, the Court of Appeals for the 3rd Circuit recently upheld a Pennsylvania statute which paid welfare benefits to 18-45 year olds only three months a year instead of twelve unless they fit into other “chronically needy” categories, while providing full annual benefits to the remaining age groups. *Price v. Cohen*, 715 F.2d 87, 89 (3rd Cir. 1983). The court stated that the legislature rationally could have concluded that the age classification was a relevant distinction that was necessary to meet the legitimate state interests of reallocating scarce welfare resources and decreasing welfare fraud. *Id.* at 95-96. Similarly, age classifications are not suspect and are subject only to minimal scrutiny. See *Vance v. Bradley*, 440 U.S. 93 (1979); *Massachusetts Bd. of Retirement v. Murgia*, 427 U.S. 307 (1976). Oregon’s scheme might be a denial of equal protection if it denied care to other suspect classes such as racial or ethnic groups. However, the Supreme Court has declared that there must be an intent to discriminate; the mere fact that one racial group is disadvantaged compared to another is not a violation of equal protection. See *Arlington Heights v. Metropolitan Hous. Div. Corp.*, 429 U.S. 252 (1977); *Washington v. Davis*, 426 U.S. 229 (1976).

22. See *supra* discussion at note 17.

23. Federal law specifies that states must cover certain services in order to be entitled to federal cost-sharing for their Medicaid programs, including, for example, “inpatient hospital services.” 42 U.S.C. § 1396d(a)(1) (1990) (Federal Medicaid regulations define “inpatient hospital services” as “services . . . that are ordinarily furnished in a hospital for the care and treatment of inpatients.” 42 C.F.R. § 442.10(a)). Other services, such as chiropractic, dental services and now certain organ transplants, are optional: the state may choose whether or not to pay for them. See HEALTH CARE FINANCING ADMINISTRATION, STATE MEDICAID MANUAL 4-203 (1988) (state “can choose to cover no organ transplant procedures, some

Justice Powell's statement in *Beal v. Doe* that "serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage."<sup>24</sup> Courts have invalidated noncoverage of liver transplants<sup>25</sup> and transsexual operations.<sup>26</sup> In view of these cases, Oregon will need to obtain a waiver from the federal government to allow it to deny necessary services to categorically needy individuals.<sup>27</sup>

One approach for Oregon to take is to obtain the necessary waiver from the Secretary of Health and Human Services. Section 1115 of the Social Security Act permits the Secretary to waive compliance with, among other things, the requirement that state Medicaid plans provide mandated benefits (interpreted by the courts, as seen earlier, to include medically necessary inpatient and other services), in the case of any experimental, pilot or demonstration project which, in the Secretary's judgment, is likely to assist in promoting the objectives of the Medicaid program.<sup>28</sup> It could be argued that, by authorizing the legislature to deny medically necessary care to Medicaid eligibles, the Oregon plan would not further the objectives of Medicaid. The purpose of Medicaid, it might be asserted, is not to provide minimal coverage to the largest number

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types of transplants and not others, or all transplants"). In addition, Medicaid is not required to pay for treatments that are deemed experimental. *See, e.g.,* *Rush v. Parham*, 625 F.2d 1150, 1156 (5th Cir. 1980).

24. 432 U.S. 438, 444 (1977).

25. *See* *Montoya v. Johnston*, 654 F. Supp. 511 (W.D. Tex. 1987) (child); *Allen v. Mansour*, 681 F. Supp. 1232 (E.D. Mich. 1986) (adult); *Lee v. Page*, No. 86-1081, CIV-J-14 (M.D. Fla. 1986) (same). This was before the Health Care Financing Administration designated coverage of liver transplants as optional in 1988. *See supra* note 23.

26. *Rush v. Parham*, 625 F.2d 1150 (5th Cir. 1980); *Pinneke v. Preisser*, 623 F.2d 546 (8th Cir. 1980).

27. Although Oregon's refusal in 1987 to cover certain transplants under Medicaid sparked the controversy that led to the enactment of Senate Bill 27, federal law is now clear that coverage of transplants is not mandatory under Medicaid. *See* HEALTH CARE FINANCING ADMINISTRATION, STATE MEDICAID MANUAL 4-203 (1988); *Ellis v. Patterson*, 859 F.2d 52, 55 (8th Cir. 1988). Therefore, Oregon will not need a waiver to deny these services. The holding in the *Ellis* case is premised on the legislative history of 1987 amendments to Medicaid. Although the decision therefore is limited to organ transplants and other services that Congress has limited expressly, the court's language is instructive in light of the Oregon rationing plan:

[W]e think plaintiff's position that all organ transplants (including hearts and lungs) must be covered by Medicaid is unrealistic. Surely Congress did not intend to require the states to provide funds for exotic surgeries which, while they may be the individual patient's only hope for survival, would also have a small chance of success and carry an enormous price tag. Medicaid was not designed to fund risky, unproven procedures, but to provide the largest number of necessary medical services to the greatest number of needy people.

859 F.2d at 55.

28. 42 U.S.C. § 1315(a).

of persons, but, through the inducement of federal cost-sharing, to insure that the categorically needy obtain necessary services. Congress has demonstrated this intent by restricting the persons whose care the federal government would help pay for under Medicaid to the "categorically" and "medically" needy, knowing full well that many other persons are unable to pay for necessary health services. However, the courts have given the Secretary wide discretion to grant waivers under section 1115: "The only limitation upon the Secretary's authority under section 1115," stated the federal district court in *Crane v. Mathews*, "is that he must judge the project to be one which is likely to assist in promoting the objectives of the applicable title of the Act . . . Congress has entrusted this judgment to the Secretary and not to the courts . . ." <sup>29</sup> Given this degree of judicial deference to the Secretary, it is unlikely that a court would strike down a waiver on the basis that a judgment by the Secretary of Health and Human Services that the denial of services was necessary to permit the size of the eligible population to be expanded was arbitrary, capricious or without a rational basis.

In any event, Oregon is seeking a waiver not simply from the Secretary of Health and Human Services, but from Congress itself.<sup>30</sup> Congressional approval of the Oregon plan is not even fettered by the minimal legal restraints the courts have placed on the

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29. *Crane v. Mathews*, 417 F. Supp. 532, 539 (N.D. Ga. 1976). The court went on to state:

Thus once a project has been approved by the Secretary, it is the function of the courts only to determine whether his decision was arbitrary and capricious and lacking in rational basis. [citations omitted.] That review is to be based on the record used by the decision-maker. . . . Given the large degree of judgment vested in the Secretary with respect to approval of 1115 projects, it is not for the courts to deny the Secretary the right to approve a project merely because the Court might in certain situations disagree with his judgment. That judgment is committed to the Secretary and must be sustained as long as he exercises it within the confines of the statute. And, as the case law shows, the only prerequisite to the exercise of that authority is that in the Secretary's judgment the demonstration or experiment furthers the objectives of the appropriate title of the Act, in this case Title XIX [Medicaid]. *Id.*

The court's interpretation of the provisions of section 1115 of the Social Security Act are also consistent with the requirements of the Administrative Procedure Act, which permits adversely affected persons to challenge the substance (as opposed to the procedures) of administrative action only on the basis that it is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law. 5 U.S.C. § 706 (1990).

30. While this arguably demonstrates the degree to which the Oregon plan is incompatible with the objectives of Medicaid, a congressional waiver probably is being sought to avoid political pressure being placed on the executive branch to deny a section 1115 waiver. See Lund, *supra* note 17, at 45 ("HCFA [the Health Care Financing Administration within the Department of Health and Human Services] can approve the waivers without Congress' permission, said Sidney Trieger, who directs the agency's [HCFA's] division of health systems. 'Given a proposal of this sensitivity, it doesn't hurt to have Congress show its support.' If



Secretary's discretion to grant waivers. Congress established Medicaid and Congress can change it or even abolish it; its action is lawful so long as it is constitutional, and as discussed above, there does not seem to be any constitutional impediment to the Oregon plan.

From a legal perspective, therefore, the main question is not whether the Oregon plan is lawful in any narrow, technical sense. Rather, the question is whether the tools of legal analysis shed any light on whether Congress and the Secretary of Health and Human Services should approve the plan as being consistent with sound public policy.

To answer this question, two issues must be addressed: First, what are the costs and benefits of the Oregon plan? Second, is it fair?

### III. COSTS AND BENEFITS

Philosophically, the Oregon plan is premised on the utilitarian principle of the greatest good for the greatest number.<sup>31</sup> This in itself is troubling, since strict utilitarianism has never been an acceptable basis for public decision-making in our society.<sup>32</sup> Instead, the Constitution and the laws flowing from it recognize a panoply of individual rights which may not be compromised merely to provide benefits to the majority. A state could not actively kill a severely ill Medicaid recipient against his or her will even though doing so would free up substantial resources for more profitable use by others. By the same token, it may be impossible to justify depriving a Medicaid recipient of a medical resource needed to save his or her life merely in order to provide basic medical services to others.<sup>33</sup>

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Oregon tries to bypass Congress, Gore says that he will introduce legislation barring HCFA from unilaterally approving the waivers").

31. See Golenski, A Report on the Oregon Medicaid Priority Setting Project 7 (Mar. 1990) (unpublished paper) ("Both efficiency and equity should be considered in allocating health care resources. Efficiency means that the greatest amount of appropriate and effective health benefits for the greatest number of persons are provided with a given amount of money. Equity means that all persons have an equal opportunity to receive available health services.").

32. Even the court in *Ellis* which refused to require states to fund transplants under Medicaid on the ground that the program was intended "to provide the largest number of necessary medical services to the greatest number of needy people," would only permit utilitarian objectives to override the provision of "risky, unproven procedures." 859 F.2d at 55.

33. Even though the Supreme Court has refused to recognize a right to health care, it might nevertheless hold that the fundamental interest in one's own life precluded a state from depriving a Medicaid recipient of a life-saving medical resource without a compelling state interest, and that expanding the population of Medicaid eligibles without increasing taxes or reducing provider reimbursement was an insufficient justification. See *Shapiro v. Thompson*, 394 U.S. 618, 632-33 (1969) (fiscal considerations ordinarily are not sufficient to sustain a

Assuming that the utilitarian approach is a defensible one, however, the acceptability of the Oregon plan depends on whether the benefits of the plan — in particular, expanding eligibility for Medicaid — outweigh the costs of denying payment for certain medical services for those presently eligible. A specific answer to this question depends on what types of care will be withheld from how many, and on what services will be extended and to how many. This is not easy to determine, since the details of the plan are still being worked out. As of this writing, the Health Services Commission has not yet issued its priority list of medical services; nor has the legislature decided at what point on that list it will draw the line. For the most part, therefore, the present inquiry must be content with examining the process by which these decisions are to be made.

In essence, the Oregon plan will establish a cost/benefit ratio for each health care service, and will rank services in order of most to least net benefit.<sup>34</sup> The guiding principle for ranking services is utilitarian: services will be ranked higher if they provide greater benefit for greater numbers of people.<sup>35</sup> The benefits of the various services will be calculated using a formula that considers the duration of the benefit, the probability that the benefit will occur, and the relative importance of the benefit as indicated by public hearings, community meetings, telephone surveys and the collective judgment of the Health Services Commission.<sup>36</sup> Costs are regarded as the costs of treatment.<sup>37</sup>

If this process accurately measured the costs and benefits of var-

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suspect classification); *Paul v. Davis*, 424 U.S. 693, 716-17 n.2 (1976) (Brennan, J., dissenting) ("there is simply no way in which the Court . . . could declare that the loss of a person's life is not an interest cognizable within the 'life' portion of the Due Process Clause.").

34. See Oregon Health Services Commission, Preliminary Report, Exhibit 5 (March 1, 1990) (unpublished report) [hereinafter OHSC Preliminary Report] ("The result is a net benefit value for each condition-treatment pair. Hundreds of condition-treatment pairs will be arrayed from the most important to the least important (the most negative numeric value to the most positive numeric value, respectively).").

35. One utilitarian dilemma is how to compare a service that yields a large amount of benefit to a small number of people with a service that yields a small amount of benefit to a large number of people. The Health Services Commission apparently will treat the benefit from these services as equivalent. See *id.* at Appendix 5 ("The efficiency of each condition/treatment pair is determined by the duration of its described outcomes. The Commission decided on this approach rather than directly taking into account the number who may benefit from a treatment. In this way, if the incidence of a condition is rare but the opportunity to correct it is high, a person will not be denied treatment on the basis of having an unusual condition.").

36. See *id.* at 10-11.

37. See *id.* at 11.

ious services, the rank ordering that it produced might be an acceptable starting point for deciding which resources to fund. However, the rankings will not represent a true measure of the benefits and costs of medical services for actual patients. Instead, it will reflect at most the views of generally healthy people toward hypothetical, future situations.<sup>38</sup> In this sense, the rankings resemble the purchase of accident insurance; they no more reflect the benefits and costs of health services than how much I choose to pay for insurance reflects the actual costs of the future accidents I may have.<sup>39</sup> The hypothetical nature of the opinions upon which the rankings are based is reinforced by the fact that, by and large, the opinions are those of people who are not Medicaid recipients and who probably do not expect ever to be in the situations they were evaluating.

Another reason for questioning the accuracy of the rankings is that a collective judgment about the value of different services does not reflect their value to the Medicaid recipient who is being forced to forego the services, any more than a physician's views on what treatment would be best for the patient necessarily reflects what the patient would choose for himself.<sup>40</sup> The Oregon approach thus runs counter to the well-established principle of informed consent, which holds that only the patient's own choices can reflect the value of alternative services.<sup>41</sup> The premise that choices can be made collectively for an individual also contradicts market theory, which holds

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38. The questionnaires on which the rankings are based stress the hypothetical nature of the responses. The telephone interviewers, for example, instruct respondents to "assume you would have no other problems than the ones described," and ask them to rate "health situations" like the following on a score from 0 to 100: "You can go anywhere and have no limitations on physical or other activity, but have a bad burn over large areas of your body." *Id.* at 1, 3.

39. The rankings are even less accurate than the purchase of insurance for purposes of valuing health services, since ranking does not involve actual payment by those doing the ranking.

40. This problem arises in connection with any decision about what services to cover that is not made by the actual patient, such as the determination by Congress that Medicaid will not cover services such as abortions. It also is characteristic of other methods for supposedly comparing the costs and benefits of health services, such as the use of "quality-adjusted life years" or "QALYs." See, e.g., K. WARNER AND B. LUCE, *COST-BENEFIT AND COST-EFFECTIVENESS ANALYSIS IN HEALTH CARE: PRINCIPLES AND POTENTIAL* 148 (1982). For this reason, some commentators stress the need to allow individuals to decide which services or benefit plans to purchase for themselves. See, e.g., A. EINTHOVEN, *HEALTH PLAN* 138 (1980).

41. See, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972). The only concession to patient autonomy in the Oregon plan is the recognition that patients should be allowed to choose between "available alternative treatments," and even this is limited by the requirement that these choices be made "in consultation with health planners." See Golenski, *supra* note 31, at 7.

that efficient outcomes can only result from individual, utility-maximizing decisions.

Even though, to the extent they are based on public opinion, the rankings reflect neither the actual costs and benefits of services, nor the preferences of the actual patients, this would not be so much of a problem if the process did not introduce systematic biases into the results. For one thing, members of the public whose views were solicited were probably aware that their responses would help to decide what services the state should provide to welfare recipients at taxpayers' expense.<sup>42</sup> Their opinions therefore may reflect the relative costs of services rather than their relative benefits.

Furthermore, the ranking process may systematically undervalue the benefit of certain services. These include services for rare diseases or conditions that most people would not expect to encounter themselves and therefore might not think are important. But particularly, the process may undervalue life-saving treatments. The legislature's decisions about costs and benefits are based on hypothetical or "statistical" lives rather than on actual or "identifiable" lives.<sup>43</sup> Statistical lives — faceless probabilities — in effect are less valuable than identifiable lives — trapped miners, babies in burning buildings, seamen on a raft, Coby Howard.<sup>44</sup> We are willing to spend more to save an identifiable life because of our natural empathy for the victim and our instinct for heroic behavior.<sup>45</sup> Yet like Coby Howard, the Medicaid eligible who is denied a life-saving

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42. See OHSC Preliminary Report, *supra* note 34, at Exhibit 3 (the community was told that, although Senate Bill 27 "means that many more people will be served, it also means that there may not be enough money to provide all the services that people may want. For this reason, the law requires that health services be ranked in order of importance.").

43. See Statement of John Kitzhaber, M.D., on SB 27, before the Health Insurance and Bio-Ethics Committee of the Oregon Senate 21-22 (undated) ("If . . . we can develop a list of priorities based on health outcomes we shift the focus of the debate from the individual to society. At that point, the debate ceases to be which individual is granted or denied which health care service. Rather, the debate becomes which service should be funded first, second, third, and fourth — for the entire population — within the context of limited resources."). For a discussion of identifiable versus statistical lives, see Fried, *The Value of Life*, 82 HARV. L. REV. 1415 (1969); Havighurst & Blumstein, *Coping With Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 NW. U. L. REV. 6, 21-25 (1975).

44. Coby Howard was a seven year-old leukemia patient who died after the Oregon legislature stopped funding Medicaid bone marrow transplants in 1987. Apparently, he died before he would have been a suitable candidate for the procedure. See Golenski, *supra* note 31, at 4. The fact that his death nevertheless generated a furor serves to underscore the high cost of rationing life-saving treatments.

45. Blumstein says that, in paying more to save an identifiable than a statistical life, we are succumbing to institutional blackmail. See Blumstein, *Constitutional Perspectives on Government Decisions Affecting Human Life and Health*, 40 LAW & CONTEMP. PROBS., Autumn 1976, at 231, 252-253. One wonders how he would account for such phenomena as love and

resource is an actual person who is identifiable to his family and friends, typically to one or more physicians or provider institutions, and perhaps to the public through the news media. By making rationing decisions on the basis of cheaper statistical lives, the Oregon legislature may discount the significant, albeit intangible, costs when a preventable death occurs, and therefore may make unwarranted trade-offs during the budget process.<sup>46</sup>

The risk that lifesaving treatments will be undervalued is borne out by the preliminary ranking undertaken by the Bioethics Consulting Group.<sup>47</sup> Organ transplants for hearts, heart/lungs, livers and bone marrow were ranked next to lowest (a rank of three on a scale from one to ten), below smoking cessation (ranked six), foot

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friendship. In any event, the aspersions he casts do not eliminate the high cost of rationing lifesaving treatment for identifiable lives.

46. For a more complete development of this issue, see Mehlman, *Rationing Expensive Lifesaving Medical Treatments*, 1985 Wis. L. Rev. 1. While legislators may be able to blind themselves to the value of identifiable lives, judges cannot, if only because the actual victim of a decision to deny health care tends to be before the court. Therefore, judicial decisions in rationing cases are likely to be more accurate reflections of the costs and benefits of rationing. It is instructive, therefore, that courts rarely have denied lifesaving treatment on utilitarian grounds. In *Montoya v. Johnston*, 654 F. Supp. 511 (W.D. Texas 1987), for example, the court rejected the state's argument that placing a \$50,000 cap on funding for transplants — which would preclude liver transplants — would make more resources available for others:

The Texas Department of Human Services opposes exceeding the \$50,000 cap claiming that there are limited funds in the Medicaid budget and that funding these procedures diverts funds from less risky and more beneficial uses as far as total recipients are concerned. The Court, however, notes that in a recent fiscal year only 95 of the approximately one million Medicaid patients in Texas exceeded the sum of \$50,000. Therefore, since only .000095 percent of all Texas Medicaid claims previously exceeded the sum of \$50,000 annually, it would appear that exceeding the limit in plaintiff's case would only have an extremely minimal effect, if any, on the funds available for other recipients. As such, the Court is of the opinion that a greater benefit is achieved in permitting funding for the transplants than in refusing to exceed the \$50,000 cap.

654 F. Supp. at 514. It is interesting that the court evidently felt that \$15 million a year ( $95 \times \$50,000$ ) was a "minimal" sum compared with the costs of allowing Medicaid recipients in need of transplants in Texas to die. Similarly, in *Todd v. Sorrell*, 841 F.2d 87 (4th Cir. 1988), the U.S. Court of Appeals, in reversing a lower court's refusal to order a liver transplant under Medicaid, balanced the costs and benefits stating: "Undoubtedly the harm to the plaintiff would have been enormous, indeed fatal, were the injunction denied, and the harm to the Commonwealth if granted, while it may not have been negligible, was measured only in money and was inconsequential by comparison." 841 F.2d at 88. Indeed, even in a recent case in which a federal appellate court interpreted the 1987 amendments to Medicaid to make coverage of certain transplants optional, the court did not allow the 10-month old plaintiff to die, since the state had agreed to fund the transplants after the suit had been filed. The court even ordered the judge below to make sure that the state provided enough resources to fund the transplants. See *Ellis v. Patterson*, 859 F.2d at 56.

47. See Golenski, *supra* note 31, at 7-9. According to Golenski, the results of this process led the Oregon legislature to enact Senate Bill 27. *Id.* at 10 ("The legislature responded to these reports by passing groundbreaking legislation.").

care for the elderly (also ranked six) and dentures (ranked seven). Only one service was ranked lower: cosmetic plastic surgery (ranked at one).<sup>48</sup> A report on the priority-setting process explains that the ranking was based on "the very small number of individuals who would benefit, the low probability of individual benefit in many cases, the poor quality of life post-procedure and the high costs of the procedures and after-care."<sup>49</sup>

It is hard to find support in the scientific literature for this view of transplant procedures. Organ transplantation is providing thousands of people with longer lives of acceptable quality. Survival rates for heart transplants show that between 73.9 and 81.9% of transplant recipients are still alive after 5 years, and 73.3% are still alive after 10 years.<sup>50</sup> Virtually all survivors report a satisfactory quality of life.<sup>51</sup> Liver transplants have a one-year survival rate of 83%.<sup>52</sup> Satisfied that the safety and efficacy of liver transplants has been established, the Health Care Financing Administration recently proposed to cover them under Medicare, at a projected cost of \$295 million.<sup>53</sup> Advances are also being made with bone marrow transplantation.<sup>54</sup> Furthermore, the cost of these transplants is decreasing.<sup>55</sup> (All of this may explain Dr. Kitzhaber's recent predic-

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48. See Golenski & Blum, *The Oregon Medicaid Priority-Setting Project 12-16* (March 30, 1989) [hereinafter *Priority Setting Report*].

49. *Id.* at 15-16.

50. Heck, Shumway & Kaye, *The Registry of the International Society for Heart Transplantation: Sixth Official Report — 1989*, 8 J. HEART TRANSPLANTATION 271, 272, 275 (1989). Heart/lung transplants have a five-year survival rate of 55.4%. *Id.* at 276.

51. See Meister, McAleer, Meister, Riley & Copeland, *Returning to Work After Heart Transplantation*, 5 J. HEART TRANSPLANTATION 154 (1986).

52. Eid, Steffen, Sterioff, Porayko, Gross, Weisner & Krom, *Long Term Outcome After Liver Transplantation*, 21 TRANSPLANTATION PROCEEDINGS 2409 (1989). In another study, all recipients reported a better quality of life and 90% reported only minor job problems 1 year after transplantation. Pennington, *Quality of Life Following Liver Transplantation*, 21 TRANSPLANTATION PROCEEDINGS 3514 (1989). Children who have received liver transplants have a one year survival rate of 69-83% and all school-aged survivors were in school with only a "no-contact-sports" restriction. Andrews, Wanek,, Fyock, Gray and Benser, *Pediatric Liver Transplantation: A Three-Year Experience*, 24 J. PEDIATRIC SURGERY 77, 82 (1989).

53. 55 Fed. Reg. 8552 (March 8, 1990).

54. The International Bone Marrow Transplant Registry reports that bone marrow transplants are increasing by 11% per year, and that victims of certain types of cancers have a 5-year, disease-free survival rate of between 40 and 60%. Bortin & Rimm, *Increasing Utilization of Bone Marrow Transplantation*, 48 TRANSPLANTATION 453, 455-56 (1989).

55. A recent study found that the cost of a heart transplant at one hospital declined from \$63,935 in 1984 to \$33,276 in 1987. Saywell, Woods, Halbrook, Jay, Nyhuis & Lohrman, *Cost Analysis of Heart Transplantation from the Day of Operation to the Day of Discharge*, 8 J. HEART TRANSPLANTATION 244, 247 (1989). Use of a new immunosuppressive drug, FK 506, reduced liver transplant costs from \$244,863 to \$134,169. See Staschak,

tion that the legislature will decide to fund at least some of these transplants.<sup>56</sup>)

The potentially unwarranted denial of lifesaving treatments is not the only cost of the Oregon plan. The categorically needy will lose their statutory entitlement to whatever other medically necessary services the legislature refuses to fund in order to increase the number of eligibles.<sup>57</sup> In addition, all Medicaid recipients will lose a number of common law rights. Senate Bill 27 provides that "any health care provider or plan contracting to provide services to the eligible population under this Act shall not be subject to criminal prosecution, civil liability or professional disciplinary action for failing to provide a service which the Legislative Assembly has not funded or has eliminated from its funding pursuant to section 8 of this Act [the provision establishing the ranking and rationing process]."<sup>58</sup> This eliminates the legal responsibility of physicians and other health care providers to ensure that their patients receive reasonable health care services. Absent the exculpatory provision in the bill, providers who refused to furnish their patients with medically necessary services merely because the state refused to pay for the services could be liable for the tort of abandonment and for malpractice.<sup>59</sup> Providers also have a legal obligation to inform patients of the risks and benefits of alternatives and to obtain the patient's informed consent to treatment.<sup>60</sup> Senate Bill 27 may protect a provider who fails to inform a patient that there is a service that the patient needs but that the provider is not supplying because it is not covered under Medicaid.<sup>61</sup>

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Wagner, Block, Van Thiel, Jain, Fung, Todo & Starzl, *A Cost Comparison of Liver Transplantation with FK 506 or CyA as the Primary Immunosuppressive Agent*, 22 TRANSPLANTATION PROCEEDINGS 47, 49 (1990).

56. Am. Med. News, March 16, 1990, at p. 20, col. 4.

57. See *supra* discussion at notes 9-15, and accompanying text.

58. Senate Bill 27, sec. 10 (codified at OR. REV. STAT. § 414.745).

59. See *Meiselman v. Crown Heights Hosp.*, 285 N.Y. 389, 34 N.E.2d 367 (1941) (hospital liable for injuries to plaintiff after discharging him prematurely due to his inability to pay); *Becker v. Jaminski*, 15 N.Y.S. 675 (1891) (jury instructed that physician owes indigent and wealthy patients same degree of care); *Ricks v. Budge*, 91 Utah 307, 64 P.2d 208 (1937) (complaint against physician who refused to continue treatment of patient who could not pay old bills). See also *Wickline v. State of California*, 228 Cal. Rptr. 661, 183 Cal. App. 3d 1064 (1986), holding that the physician is responsible for insuring adequate patient care despite cost constraints imposed by third-party payers.

60. See *Canterbury v. Spence*, 444 F.2d 772 (D.C. Cir. 1972).

61. The bill contains a provision that requires the provider to inform the Medicaid recipient "of any service that is medically necessary but not covered under the contract [with the state] if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances." Senate Bill 27, sec. 6(7) (codified at OR. REV. STAT. § 414.725(7)). Since the Oregon plan is unique, it is impossible to know what another

The costs of the Oregon plan, however, must be weighed against its benefits. By spending less on current eligibles, funding will be available to extend coverage to more people. Senate Bill 27 expands eligibility to all persons whose incomes are below the federal poverty level. Although this potentially comprises 138,000 people,<sup>62</sup> only 10,000 are expected to enroll in the program by the end of the first budget cycle.<sup>63</sup> Furthermore, unless the legislature drastically cuts services the savings may not be significant. Estimates on how much money was saved by withdrawing funding from transplants during the 1987-1989 budget cycle range between \$550,000 and \$1.1 million a year.<sup>64</sup> The larger estimate is less than one per cent of Oregon's Medicaid expenditures as projected for fiscal year 1990-1991.<sup>65</sup>

Expanding the population entitled to receive services under Medicaid is not the only benefit from Senate Bill 27. It will also increase payments to providers of care,<sup>66</sup> and will prevent their reimbursement from being reduced if the program costs more than the legislature originally estimates.<sup>67</sup> For example, it has been estimated that the higher reimbursement rates will provide an additional \$1.4 million in payments to providers during the first year of the program.<sup>68</sup> The increase in provider reimbursement arguably

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provider would tell a patient in the same situation, and therefore impossible to predict how this provision will be interpreted.

62. See Golenski, *supra* note 31, at 2-3 ("Given Oregon's Medicaid eligibility restrictions, of the 300,000 residents living at or below the Federal Poverty Level, only 162,000 qualify for Medicaid").

63. See Shostak, *supra* note 17, at 3; OREGON ASSOCIATION OF HOSPITALS, RATIONING AND MANDATES, in CAPITOL COMMENTS: 1989 LEGISLATIVE INITIATIVES 1 (undated) ("... officials anticipate approximately 10,200 new enrollees the first year").

64. See Welch and Larson, *supra* note 7, at 171 (Oregon Division of Adult and Family Services estimated transplant costs during 1987-1989 of \$2.2 million), 172 (giving Craig Irwin's estimate that the state would have spent only \$1.1 million on transplants during 1987-1989).

65. See Shostak, *supra* note 17, at 3 (projecting \$174 million available to spend during 1990-1991).

66. See Lund, *supra* note 18, at 45 ("the program anticipates raising the fees paid to physicians and hospitals . . ."). See also OREGON ASSOCIATION OF HOSPITALS, *supra* note 63, at 2 ("We anticipate that . . . those providers who contract to provide services will be adequately reimbursed"; "[t]he concepts embodied in this legislation are dependent upon removing the current financial disincentive to provide care . . .").

67. See Senate Bill 27, sec. 8(1)(b) (codified at OR. REV. STAT. § 414.735(1)(b)) ("If insufficient resources are available during a contract period . . . [t]he reimbursement rate for providers and plans established under the contractual agreement shall not be reduced.").

68. This is based on projections by Shostak that HMO contracts would increase from approximately \$90 per enrollee per month to \$102. See Shostak, *supra* note 17, at 4.



will increase access for Medicaid recipients, and enhance the quality of the providers willing to treat them.

Senate Bill 27 also is intended to help hold the line on tax increases and other methods of increasing the funds available for Medicaid. As Dr. Kitzhaber notes:

The first reality is that our resources are limited. This is particularly true in our state where we have not only a constitutional requirement to live within a balanced budget, but an expenditure limitation and a revenue limitation as well. . . . We are acutely aware that there is a limit to the level of taxation that the public will tolerate. . . . When money is spent on one set of services it is, by definition, not available to spend on other services. Health care services must compete with all the other legitimate services state government must provide.<sup>69</sup>

By withholding payment for services that rank low on the priority list, Senate Bill 27 enables the state to limit the funds needed to pay for its expanded Medicaid program by controlling how much it spends.

A final potential benefit is that the Oregon plan creates a mechanism that makes rationing decisions public. This forces the legislature and the public to confront the hard choices before them, rather than allowing them to be made by default or by individual health care providers in a manner that shields them from public view. In fact, some people believe that the prospect of rationing will prompt the legislature to increase funding for Medicaid rather than to cut necessary services.<sup>70</sup> On the other hand, Oregonians are reported to be extremely reluctant to increase taxes to pay for greater coverage,<sup>71</sup> and their political leaders seem unwilling to try to change their minds.<sup>72</sup> Indeed, the legislature's decision to halt funding for transplants in 1987 suggests that the state will allow people to die

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69. Statement of John Kitzhaber, M.D., *supra* note 43, at 13.

70. See, e.g., Meyer, *Rationing Questions Loom with Oregon Plan*, Am. Med. News, Aug. 25, 1989, at 10, col. 2 (statement by chairman of Oregon Health Services Commission that "[p]eople are worried that the legislature may be inclined to spend less after looking at the list. But I think they might spend more because they'll see that the list of what's covered will be short if they appropriate \$1 million and pretty long if they appropriate \$500 million.").

71. See, e.g., Robinson, *Who Should Receive Medical Aid?*, PARADE, May 28, 1989. (93% of those Oregonians polled said that every American has a right to health care, but "the majority voted overwhelmingly against any increase in taxes to pay for it").

72. The degree of Dr. Kitzhaber's interest in increasing funding for Medicaid may be indicated by his statement that "[f]unding more services may require raising taxes or taking money out of the schools." Meyer, *Oregon Medicaid Plan Gets Boost from Health Care Executives' Poll*, Am. Med. News, March 16, 1990, at 20, col. 4.

rather than come up with increased funding for expensive life-saving services.

Will the benefits that can be expected from the Oregon plan — expanded eligibility, increased payments to providers, fiscal conservatism and public rather than private decisions on rationing — outweigh the costs in terms of medically necessary services withheld, legal rights forfeited, and lives lost in a spectacle of public indifference? The answer is not clear-cut. More fundamentally, it is not evident how the benefits can actually be compared with the costs. How does one value a life,<sup>73</sup> or the requirement that rationing decisions be made publicly? Insofar as the Oregon plan is designed to make these trade-offs based on these factors, it may end up making rationing decisions in a largely arbitrary fashion.

#### IV. FAIRNESS

Even if the costs of the Oregon plan do not outweigh the benefits, the plan may be objectionable on the grounds of fairness. It is a zero sum game; in order to expand the number of eligibles, someone else must give something up. As noted at the outset, what is given up could be revenues to providers or the income of taxpayers. But under Senate Bill 27 it is the scope of covered services.<sup>74</sup> To determine if the plan is fair, therefore, the first question that must be asked is: who wins, and who loses?

The primary losers under the Oregon plan are those persons who were eligible for Medicaid before the enactment of Senate Bill 27. Generally speaking, these are the poorest people in the state. They comprise persons who qualify for Aid to Families with Dependent Children (principally single parents and their children).<sup>75</sup> Most of these families have incomes below 58% of the federal poverty level. Some, the so-called “medically needy” have incomes above this threshold but would drop below it if they had to pay

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73. For a discussion of the possibilities, see Mehlman, *Health Care Cost Containment and Medical Technology: A Critique of Waste Theory*, 36 Case W. Res. L. Rev. 778, 791-99 (1986).

74. See *supra* discussion at notes 8-16 and accompanying text.

75. Prior to the passage of Senate Bill 27, Oregon's Medicaid program also covered the other major group mandated as categorically needy under federal law, those persons who qualify for Supplemental Security Income — primarily the aged, blind and disabled. Senate Bill 27 expressly exempts them from its rationing scheme. See Senate Bill 27, sec. 3(2) (codified at OR. REV. STAT. 414.710(3)); Kosterlitz, *Oregon Wants a Little Medicaid Slack*, 21 NAT'L J. 2766 (1989) (“Also viewed suspiciously by [Congressman] Waxman's staff is the fact that the state's plan would exempt the elderly and disabled medicaid [sic] recipients, who are represented by powerful lobbies”). Section 3(2) of the bill also exempts long-term care from the prioritization process.

their medical bills. In addition, some persons are eligible to receive Medicaid benefits by virtue of receiving state general assistance or emergency assistance.<sup>76</sup> As the Oregon plan progresses and more eligibles enroll, it can be expected that more services will be dropped. Therefore, losers under the plan include each group of eligibles whose services are cut to make way for later waves of enrollees.<sup>77</sup>

Who wins? The obvious winners are those Oregonians who were not eligible for Medicaid prior to the expansion of the program in Senate Bill 27. These are persons who would qualify for Aid to Families with Dependent Children except that their incomes, while still below the federal poverty level, were above the state income thresholds, plus childless couples and single adults who do not receive general or emergency assistance. There is no question that these people are far from being well-off, or that they need and deserve access to basic medical services. What is striking, however, is that they are by and large somewhat better off than those who were eligible for Medicaid before the plan was adopted. That is, they are persons whose incomes are higher, or who are employed, or who are not dependent children.<sup>78</sup>

In essence, then, the Oregon plan shifts resources from the worst off to those slightly better off. This alone raises doubts about its fairness. The objection is not that the newly eligible will be covered under the program. The question instead is whether it is fair to expand the eligibility requirements by taking medically necessary resources away from those who are even worse off. This would seem to violate the principle that a redistribution of resources is unjust unless it benefits the least advantaged in society.<sup>79</sup>

However, the newly eligible are not the only persons to benefit from the Oregon plan. The provider reimbursement provisions of Senate Bill 27 mean that providers will not have their reimbursement levels reduced in order to pay for expanded eligibility.<sup>80</sup> In

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76. The federal government does not contribute to the costs of providing care for these last two groups.

77. See *supra* discussion at note 17 and accompanying text.

78. There is undoubtedly a layer of persons just above those who were eligible to receive Medicaid prior to the passage of Senate Bill 27 who, as a result of not being eligible, were in fact poorer than persons who earned less but were eligible. But the expanded group of eligibles clearly includes persons who, while still poor, have a higher standard of living than those who previously were entitled to Medicaid.

79. See J. RAWLS, A THEORY OF JUSTICE 302 (1971).

80. See discussion at notes 66-68, *supra*, and accompanying text. Senate Bill 27 requires that providers be reimbursed at "rates necessary to cover the costs of services." Senate Bill 27, sec. 4a(3) (enacted as OR. REV. STAT. 414.720(3)); Coopers & Lybrand, Oregon Medicaid

fact, provider reimbursement will increase.<sup>81</sup> Ironically, estimates of the additional amount that will be paid to providers during the first budget cycle of the new program correspond closely to the amount that would have been spent on transplants if the legislature had not banned coverage of them in 1987.<sup>82</sup> Again, this is not to say that providers do not deserve higher rates of reimbursement. Rather, the point is that it is unfair for providers to receive the additional funds at the expense of persons who are substantially less well off.

The final winners under the Oregon plan are taxpayers and other funding sources for the state's Medicaid budget, if we assume that the rationing process allows the legislature to hold the line on tax increases to pay for expanded eligibility.<sup>83</sup> In fact, the winners might be defined more specifically as Oregon businesses, and particularly small businesses, since a standard alternative for funding expanded eligibility or increased services is to increase business taxes.<sup>84</sup> Tax stability for those who earn enough to pay taxes, and

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Prioritized Health Care System: Final Report on Capitation Methods and Methods for Defining Necessary Costs 1, 4 (March 23, 1990) (unpublished report). This contrasts with the prior approach to dealing with increased program costs which was to decrease reimbursement to providers. See, e.g., Kitzhaber, *supra* note 8, at 5 ("Money can also be saved for the state by cutting provider reimbursement rates. In Oregon, the average provider reimbursement reflects a 55% discount"); *Id.* at 11 ("It would be clear to anyone who has taken a serious look at the Medicaid program at the state level . . . that when the federal government mandates additional services on the Medicaid program, without providing adequate federal revenues, that [sic] the states (which unlike the federal government, must operate within the constraints of a balanced budget) are often forced to respond by changing eligibility and/or further reducing provider reimbursement.").

81. See *supra* discussion at notes 66-68 and accompanying text. In contrast to the current level of "discounted" reimbursement, the accounting firm that is designing the cost-based payment system recommends in the case of physician fees, for example, that a panel of providers be convened "to assist in the determination of necessary costs based on the available data considering overhead costs and an adequate salary." Coopers & Lybrand, *supra* note 80, at 24.

82. Compare Welch and Larson, *supra* note 6, (citing Oregon Division of Adult and Family Services estimate that transplants would have cost \$1.1 million per year during the 1987-1989 cycle) with Shostak, *supra* note 16, (providing basis for estimate that providers will receive an additional \$1.4 million per year during the first two years of the program).

83. See *supra* discussion at note 69 and accompanying text.

84. See *Priority Setting Report*, *supra* note 48, at 1-2 ("Most states which are struggling with the twin problem of uncompensated care and uninsured citizens are implementing laws or regulations which will require employers to bear most of the increased burden of funding services, either through taxation or mandatory health benefits"). The Oregon legislature has in fact adopted this approach in part; Senate Bill 935 (codified within OR. REV. STAT. §§ 316.096, 317.113, 353.725, 353.765, 353.775 (1989)), passed together with Senate Bill 27, requires employers to provide insurance coverage to employees or dependents by 1994, or to contribute to a state insurance fund. See OREGON HOUSE OF REPRESENTATIVES, STAFF MEASURE SUMMARY ON SB 935-B (May 31, 1989). Presumably the amount of employer

enhanced competitiveness for Oregon businesses, are no doubt worthwhile objectives, but again one must ask if it is fair to achieve them by imposing burdens on those who are worse off.

In sum, almost without exception, Senate Bill 27 allows the better off to benefit by stripping medically necessary resources from the worst off. In some cases, those who benefit, such as newly eligible persons whose incomes are only slightly higher than the state thresholds, are better off only marginally, if at all, compared with those who lose. In other respects, however, the approach is more unfair. For example, by precluding or reducing tax increases for the wealthiest taxpayers in the state, the plan takes resources from the worst off to benefit the best off.

It is important to bear in mind that, in this sense of fairness, when the winners are better off than the losers from the start, the Oregon plan would be unfair even if it conferred an enormous benefit on the winners and caused only a modest loss for the losers. The degree of unfairness, of course, would vary depending on the details of the rankings and the resulting rationing scheme. The greater the benefit compared to the loss, the less unfair it would be. Similarly, the more the costs of the withheld services exceeded their benefits, the more difficult it would be to justify imposing those costs even on the better off members of society. But the preliminary ranking gives little comfort on these scores: the fate of those in need of transplants suggests that what the losers stand to lose is not trivial, and that, while the costs of the foregone services may be high, so in many cases are their benefits.

## V. ALTERNATIVES

Although it may make it more difficult for the craftsmen of the Oregon plan to be sanctimonious about their endeavors, there is little practical purpose in raising doubts about the justice of the plan unless a better approach can be devised. Since there are only a few variables that can be manipulated, the choices are limited.

One alternative is suggested by Arthur Caplan. "[I]t is hard to think of a moral or religious ethic that holds that when a nation cannot pay its doctor bills, it is the poor and only the poor who should be denied the right to see a doctor," he writes. "It is hard to understand how any ethicist could become involved in a scheme so blatantly unfair as that of rationing necessary health care only for

the poor.”<sup>85</sup> One implication of these remarks is that, if care must be rationed because it cannot be provided to all, it should be provided to none. This is not an entirely outlandish idea: during the dialysis rationing crisis of the 1960s, at least one hospital closed its dialysis facility altogether rather than providing dialysis only to those who could pay.<sup>86</sup> Yet, short of preventing a medical resource from being developed in the first place, it is hard to imagine how it could be denied to everyone, including those wealthy enough to purchase it on their own either in this country or abroad.<sup>87</sup>

The discussions in Parts II and III above suggest that Oregon should not expand Medicaid eligibility by denying medically necessary services. Assuming that Oregon desires to expand eligibility, the obvious alternatives are to increase program funding or to decrease provider revenues. Both of these approaches are problematic. Increasing program funding means increasing taxes, and Oregonians seem to be unwilling to do this.<sup>88</sup> On the other hand, decreasing provider revenues risks driving providers away from the program. This jeopardizes access to care for Medicaid eligibles and may reduce quality. Moreover, reducing payments disproportionately affects those providers who treat large populations of Medicaid patients, and who therefore may be among the least well-off providers.<sup>89</sup> Finally, unless services are cut, some increase in program funding seems necessary, since it is unlikely that payments to providers could be reduced sufficiently to lower the costs of the expanded program to the break-even point.

Since increasing funding seems inevitable, and arguably is preferable to expanding eligibility by reducing provider reimbursement,

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85. See Caplan, *How Can We Deny Health Care to Poor While Others Get Face Lifts?* Los Angeles Times, April 25, 1989, at 7, col. 2.

86. See Note, *Scarce Medical Resources*, 69 COLUM. L. REV. 620, 653 (1969).

87. See Mehlman, *Aged-Based Rationing and Technological Development*, 33 ST. LOUIS U. L. J. 671, 673 (1989); D. Callahan, *SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY* 199 (1987); Mehlman, *supra* note 74, at 836-47 (describing methods for discouraging the development and diffusion of socially undesirable medical technologies). Callahan points out that a public attempt to outlaw medically necessary technology for everyone would most likely spawn a black market, with socially disruptive consequences.

88. See discussion *supra* at notes 83-84 and accompanying text.

89. While in the past providers may have been able to increase charges to other patient groups to make up for Medicaid payment reductions, increasingly stringent cost containment efforts by employers and insurers reduces the availability of this alternative. See Statement of John Kitzhaber, M.D., *supra* note 43 at 2-11. Caplan proposes that providers be required by law to furnish a percentage of care for the indigent. See Caplan, *supra* note 85. This is similar to the idea of reducing provider revenues, since it imposes the costs of expanding the program solely on providers, assuming that they will be unable to pass these costs on to other patients.

the question is: What should be the source of the additional funds? Part of the design of the Oregon plan is to obtain some additional funding from the federal government. This is one of the reasons, it will be recalled, for obtaining waivers from the federal government.<sup>90</sup> But even if the waivers were granted, the federal government would provide only a portion of the additional funds that were needed; under federal-state cost sharing, the state would still have to come up with its share of the Medicaid budget.<sup>91</sup>

Of course, where to find the funds to provide necessary health care services to all American citizens regardless of their ability to pay is one of the great political issues of our time, and the precise answer is beyond the scope of this paper. Some guidelines, however, might be considered.

While the courts have not explicitly accorded health care the status of a right, they seem to recognize that it is a special type of good that should not be subject solely to market forces and ordinarily should not be withheld because of the patient's inability to pay.<sup>92</sup> This is consistent with the following principle of distributive justice: necessary health services should not be withheld merely in order to maintain inequalities of wealth. In other words, it is more appropriate to expand eligibility by requiring the better off to subsidize the less well-off, than by requiring the less well-off to forego necessary services. This leads to quite a different approach than Senate Bill 27. Instead of figuring out how much the legislature has to spend on Medicaid, and then determining which medically necessary services this will pay for in order of priority, the state ought to determine which services are medically necessary, and then figure out how much revenue will be required to pay for them.

Several objections might be made to this approach. First, Oregonians are unwilling to have their taxes raised, and therefore this approach is politically unfeasible. This may be true of taxing systems that lean too heavily on the less well-off, as demonstrated by the demise of the Medicare Catastrophic Coverage Act of 1988. However, it should be possible to design a taxing scheme that is

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90. See *supra* discussion at note 17 and accompanying text.

91. In any event, relying on federal funds to expand coverage merely pushes the question one step back: Where would the federal government get the funds?

92. In addition to the cases cited *supra* at note 59, there is the famous case of *U.S. v. Holmes*, in which the court stated that drawing lots was the fairest method for deciding who should be thrown out of an overcrowded lifeboat so that not all the passengers would drown: "[W]e can conceive of no mode so consonant both to humanity and to justice; and the occasion, we think, must be peculiar which will dispense with its exercise." 26 F. Cas. 360, 367 (E.D. Pa. 1842) (No. 15,383).

sufficiently graduated to attract the necessary public support, especially if the benefits were used, in conjunction with other sources, to fund comprehensive health insurance for all.<sup>93</sup> Incidentally, this would avoid placing a disproportionate burden on providers of care — either by drastically reducing their reimbursement or by requiring them to treat the poor free-of-charge. Instead, funds would be obtained from providers just like everyone else, with those who were in the highest income brackets paying proportionately more than their colleagues who were less off.

A second objection is that, even with increased funding, economic resources are finite, while new, cost-increasing medical technology will continue to be developed indefinitely.<sup>94</sup> Initially, it should be noted that this is a problem separate from how to provide health care for the poor under Medicaid, since the unrestrained growth of medical technology eventually will engulf even the resources of the rich. In any event, there are two approaches to dealing with this problem. The first is to attempt to discourage technological innovation, or at least to discourage cost-increasing innovation. Given the manner in which medical advances take place, this is extremely difficult to accomplish directly.<sup>95</sup> The alternative is to define what is “medically necessary” so that certain expensive services are not purchased. At first, this may sound like Senate Bill 27 all over again, with the term “medically necessary” substituted for what remains of the list of ranked services once the legislature decides what it will pay for. Given the justice principle described earlier, however, the inquiry is quite different: unlike the Oregon plan, the list of “medically necessary” services would be determined on a clinical basis<sup>96</sup> without regard to the wealth of the recipient, but with the knowledge that whatever graduated taxing

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93. Caplan proposes a “luxury tax, which could be used to help meet the crucial health-care needs of the poor . . . .” Caplan, *supra* note 85. A steeply graduated income tax may be wiser economically than this type of excise tax.

94. See, e.g., Aaron and Schwartz, *Rationing Health Care: The Choice Before Us*, 247 *SCI.* 418, 421 (1990) (“The strongest evidence that the United States will have to ration care if it wishes to slow growth of health care spending on a sustained basis comes from the creativity of medical scientists, who continue to develop new services that promise both significant benefits for large numbers of people and large added costs for public and private budgets. Indeed, the flow of technological innovation shows little sign of abating and may be accelerating.”).

95. See Mehlman, *supra* note 74, at 799-833 (1986).

96. This would be aided by improving techniques of outcome assessment that helped to identify clinically superior and cost-effective technologies. For a description of these techniques, see INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, *MEDICARE: A STRATEGY FOR QUALITY ASSURANCE* (1990).



mechanism was adopted would be relied on to supply the funds necessary to insure that the services were available to all.<sup>97</sup> Services could be rationed under this approach, but on the basis that — like cosmetic face-lifts — they were not medically necessary for anyone, including the wealthy.<sup>98</sup> Conversely, if a service were deemed to be medically necessary for the wealthy, the funding mechanism would see to it that it was available to all.<sup>99</sup>

## VI. CONCLUSION

In their discussion of the Oregon legislature's 1987 decision to halt Medicaid funding for transplants, Welch and Larson state that, "[w]hatever one's views on the outcome the Oregon legislature is to be commended for confronting such a difficult issue."<sup>100</sup> Whether they are correct depends on the future of Senate Bill 27. Its fate is in the hands of Congress and the Department of Health and Human Services. If Oregon gets the waivers it is seeking, then Senate Bill

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97. In deciding what services a state must provide under Medicaid, the courts have interpreted "medically necessary" to mean care that is not experimental and that is "medically appropriate," and have stated that it is the primary responsibility of the patient's physician to determine what is necessary. See, e.g., *Montoya v. Johnston*, 654 F. Supp. 511, 513 (W.D. Tex. 1987). Other courts have focused on the fact that the treatment is the only alternative to treat a serious or life-threatening illness. See, e.g., *Allen v. Mansour*, 681 F. Supp. 1232, 1238 (E.D. Mich. 1986) ("This operation is the only treatment available to resolve his liver disease . . ."). While some of these factors would be relevant in the decision-making process I have in mind, the individual physician's judgment would be limited by collective clinical decisions. This might resemble the coverage policy-making process used by Medicare, or the consensus conference approach used by the Office of Medical Applications of Research of the National Institutes of Health. It is noteworthy that, unlike Oregon, Medicare has proposed to fund liver transplants. See *supra* discussion at note 53 and accompanying text.

98. If the service were still available despite the decision that it was not medically necessary, better-off persons would be able to purchase it for themselves just as they now can purchase amenities such as private hospital rooms, or certain experimental cancer treatments. Similarly, those better off would still be able to purchase a different quality of service, such as an operation from a renowned surgeon, within certain quality limits established by providers, by the government, and by the market-place. See generally, *Mehlman, Assuring the Quality of Medical Care: The Impact of Outcome Measurement and Practice Standards*, 18 L. Med. & Health Care 368 (1990).

99. Since this approach entails some form of collective decision-making to determine what is and is not medically necessary, it is subject to the objection that it ignores the patient's personal preferences. Given the choice, for example, a person might prefer a face-lift to a liver transplant. I see no way around this objection, except to point out that, within broad limits, we seem willing to accept certain constraints on our decision-making autonomy. The doctrine of informed consent, for example, does not require a physician to inform the patient of all alternatives, but only of reasonable alternatives. See, e.g., *Canterbury v. Spence*, 464 F.2d at 787. In any event, since this is a problem with the Oregon plan too, it is certainly not a reason for preferring that approach to this one.

100. Welch and Larson, *supra* note 7, at 172.

27 will become a beacon for other legislatures to follow,<sup>101</sup> and explicit, wealth-based rationing of health care will proliferate. The poor will be the first victims, but not the last: The *New York Times* reports officials in Oregon and Alameda County, California, as saying that they hope the Oregon approach will "provide a model for rationing of care for the middle class. . . ."<sup>102</sup> If the waivers are denied, and rationing of necessary health services to perpetuate economic inequalities is recognized as being morally indefensible, then the Oregon legislature will have served us well, for in that case, Senate Bill 27 will represent the milepost that finally makes us realize that we have gone down the wrong road.

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101. See Lund, *supra* note 18, at 46 (similar efforts underway in Colorado, Kentucky, Alaska, Florida and California).

102. Gross, *What Medical Care the Poor Can Have: Lists Are Drawn Up*, *New York Times*, March 26, 1989, at 1, col. 1.

